1020 - MEDICAL MANAGEMENT SCOPE AND COMPONENTS

EFFECTIVE DATES: 10/01/94, 11/01/05, 10/01/08, 03/01/11, 01/01/11, 04/01/12, 02/01/15, 03/01/15, 10/01/15, 04/05/17, 07/01/17

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I. PURPOSE

This Policy applies to Acute Care, CRS, CMDP, DDD , ALTCS/EPD, RBHA Contractors; Fee-For-Service (FFS) Programs as delineated within this policy including: Tribal ALTCS, TRBHAs. This Policy outlines requirements for the Contractor to develop an integrated process or system that is designed to assure appropriate utilization of health care resources, in the amount and duration necessary to achieve desired health outcomes, across the continuum of care from prevention to hospice, including Advanced Care Planning at any age or stage of illness.

II. DEFINITIONS

ADVANCE CARE PLANNING

Advance care planning is a part of the End of Life care concept and is a billable service that is a voluntary face-to-face ongoing discussion between a qualified health care professional and the member to:

1. Educate the member/guardian/designated representative about the member's illness and the health care options that are available to them,
2. Develop a written plan of care that identifies the member's choices for treatment, and
3. Share the member's wishes with family, friends, and his or her physicians.

ARIZONA STATE HOSPITAL (AZSH)

Provides long-term inpatient psychiatric care to Arizonans with mental illnesses who are under court order for treatment.

CONDITIONAL RELEASE PLAN (CRP)

If the psychiatric security review board finds that the person still suffers from a mental disease or defect or that the mental disease or defect is in stable remission but the person is no longer dangerous, the board shall order the person's conditional release. The person shall remain under the board's jurisdiction. The board in conjunction with the state mental health facility and behavioral health community providers shall specify the conditions of the person's release. The board shall continue to monitor and supervise a person who is released conditionally. Before the conditional release of a person, a supervised treatment plan shall be in place, including the necessary funding to implement the plan as outlined in A.R.S. §13.3994.

EMERGENCY MEDICAL CONDITION

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: a) placing the patient's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, b)serious impairment to bodily functions, or c) serious dysfunction of any bodily organ or part [42 CFR 438.114(a)].

END-OF-LIFE CARE

A concept of care, for the duration of the member's life, that focuses on Advance Care Planning, the relief of stress, pain, or life limiting effects of illness to improve quality of life for a member at any age who is currently or is expected to experience declining health, or is diagnosed with a chronic, complex or terminal illness.

HEALTH CARE-ACQUIRED CONDITION (HCAC)

A Hospital Acquired Condition (HAC) under the Medicare program, with the exception of Deep Vein Thrombosis/Pulmonary Embolism following total knee or hip replacement for pediatric and obstetric patients, which occurs in any inpatient hospital setting and which is not present on admission.

MEDICATION ASSISTED TREATMENT (MAT)

The use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery.

OTHER PROVIDER-PREVENTABLE CONDITION (OPPC)

A condition occurring in the inpatient and outpatient health care setting which AHCCCS has limited to the following:

1. Surgery on the wrong member,
2. Wrong surgery on a member, and
3. Wrong site surgery.

PRACTICAL SUPPORT

Non-billable services provided to a member by a family member, friend or volunteer to assist or perform functions such as, but not limited to; housekeeping, personal care, food preparation, shopping, pet care, or non-medical comfort measures.

PSYCHIATRIC SECURITY REVIEW BOARD (PSRB)

The psychiatric security review board is established consisting of the following members who are appointed by the governor pursuant to A.R.S. §38-211 as outlined in A.R.S. §31-501 experienced in the criminal justice system:

1. One psychiatrist,
2. One psychologist,
3. One person who is experienced in parole, community supervision or probation procedures,
4. One person who is from the general public,
5. One person who is either a psychologist or a psychiatrist.

VIVITROL

An opioid antagonist that blocks opioid receptors in the brain for one month at a time, helping patients to prevent relapse to opioid dependence, following detoxification, while they focus on counseling and treatment.

III. POLICY

A. UTILIZATION DATA ANALYSIS AND DATA MANAGEMENT

Contractor must have in effect mechanisms to review utilization and detect both underutilization and over utilization of services (42 CFR 438.330(b)(3)). Contractor must develop and implement processes to collect, validate, analyze, monitor, and report the utilization data. On an ongoing basis, the MM Committee must review and evaluate the data findings and make or approve recommendations for implementing actions for improvement when variances are identified. Evaluation must include a review of the impact to both service quality and outcome. The MM Committee must determine, based on its review, if action (new or changes to current intervention) is required to improve the efficient utilization of health care services. Intervention strategies to address both over and underutilization of services must be integrated throughout the organization. All such strategies must have measurable outcomes that are reported in MM Committee minutes.

Refer to AMPM Policy 810 for FFS Utilization Management policies.

B. CONCURRENT REVIEW

Contractor must have policies, procedures, processes and criteria in place that govern the utilization of services in institutional settings. Contractor will have procedures for review of medical necessity prior to a planned institutional admission (precertification) and for determination of the medical necessity for ongoing institutional care (concurrent review).

1. Policies and procedures for the concurrent review process must:
   a. Include relevant clinical information when making hospital length of stay decisions. Relevant clinical information may include but is not limited to symptoms, diagnostic test results, diagnoses, and required services,
   b. Specify timeframes and frequency for conducting concurrent review and decisions:
      i. Authorization for institutional stays that will have a specified date by which the need for continued stay will be reviewed, and
      ii. Admission reviews must be conducted within one business day after notification is provided to the Contractor by the hospital or institution (this does not apply to precertifications) (42 C.F.R. 456.125).
   c. Provide a process for review that includes but is not limited to:
      i. Necessity of admission and appropriateness of the service setting,
      ii. Quality of care,
      iii. Length of stay,
      iv. Whether services meet the member needs,
      v. Discharge needs, and
      vi. Utilization pattern analysis.
   d. Establish a method for the Contractor participation in the proactive discharge planning of all members in institutional settings.

2. Criteria for decisions on coverage and medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.
   a. Medical criteria must be approved by the Contractor MM Committee. Criteria must be adopted from national standards. When providing concurrent review, the Contractor must compare the member's medical information against medical necessity criteria that describes the condition or service,
   b. Initial institutional stays are based on the Contractor adopted criteria, the member's specific condition, and the projected discharge date,
   c. Continued stay determinations are based on written medical care criteria that assess the need for the continued stay. The extension of a medical stay will be assigned a review date each time the review occurs. The Contractor ensures that each continued stay review date is recorded in the member's record,
   d. The CRS Contractor concurrent review staff must coordinate with the inpatient facility's Utilization Review Department and Business Office, when there is any change to the CRS authorization status or level of care required for Fully Integrated CRS members and CRS Partially Integrated Acute,
   e. The CRS Contractor concurrent review staff must notify the AIHP, CMDP, or DDD Contractor's concurrent review staff when they become aware that a CRS Partially Integrated Behavioral Health or CRS only member is admitted to the hospital,

f. Conversely, the AIHP, CMDP, or DDD Contractor's concurrent review staff must notify the CRS Contractor's concurrent review staff when they become aware that a CRS Partially Integrated Behavioral Health or CRS only member is admitted to the hospital,
g. Coordination will include proactive discharge planning between all potential payment and care sources upon completion of the CRS related service, and
h. Contractor must submit the Contractor Quarterly Showing Report for Inpatient Hospital Services as specified in Contract.

C. DISCHARGE PLANNING

Contractor shall have policies and procedures in place that govern the process for proactive discharge planning and coordinating services the Contractor furnishes to the member between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

The intent of the discharge planning process is to increase the management of inpatient admissions, improve the coordination of post discharge services, reduce unnecessary hospital stays, ensure discharge needs are met, and decrease readmissions within 30 days of discharge.

Contractor shall develop and implement a discharge planning process that ensures members receiving inpatient services have proactive discharge planning to identify and assess the post-discharge bio-psychosocial and medical needs of the member in order to arrange necessary services and resources for appropriate and timely discharge from a facility.

A proactive assessment of discharge needs shall be conducted prior to admission when feasible.

Discharge planning shall be performed by a qualified healthcare professional and initiated on the initial concurrent review, updated periodically during the inpatient stay, and continued post discharge to ensure a timely, effective, safe and appropriate discharge.

The Contractor staff participating in the discharge planning process shall ensure the member/guardian/ designated representative, as applicable:

1. Is involved and participates in the discharge planning process,

2. Understands the written discharge plan, instructions and recommendations provided by the facility, and

3. Is provided resources, referrals and possible interventions to meet the member's assessed and anticipated needs after discharge.

Discharge planning, coordination and management of care shall include:

1. Follow-up appointment with the PCP and/or specialist within seven days,

2. Safe and clinically appropriate placement, and community support services,

3. Communication of the member's treatment plan and medical history across the various outpatient providers, including the member's outpatient clinical team, TRBHA and other Contractor when appropriate,

4. Prescription medications,

5. Medical Equipment,

6. Nursing services,

7. End of Life Care related services such as Advance Care Planning,

8. Practical supports,

9. Hospice,

10. Therapies (AHCCCS limits outpatient physical therapy visits for members 21 years of age and older). (See AMPM Policy 310-X),

11. Referral to appropriate community resources,

12. Referral to Contractor Disease Management or contractor care management (if needed),

13. A post discharge follow-up call to the member within three days of discharge to confirm the member's well-being and the progress of the discharge plan according to the member's assessed clinical (behavioral and physical health) and social needs,

14. Additional follow-up actions as needed based on the member's needs, and

15. Proactive discharge planning when the Contractor is not the primary payer.

D. PRIOR AUTHORIZATION AND SERVICE AUTHORIZATION

The Contractor must have Arizona licensed Prior Authorization (PA) staff that includes a nurse or nurse practitioner, physician or physician assistant, pharmacist or pharmacy technician, or licensed behavioral health professional with appropriate training to apply the Contractor's medical criteria or make medical decisions.

Refer to AMPM Policy 1630, for qualifications of staff members who may authorize long term care home and community based services that are not considered skilled.

Refer to AMPM Policy 310-F for additional information regarding emergency services.

Refer to AMPM Policy 820 for FFS Prior Authorization Requirements.

The Contractor shall develop and implement a system that includes at least two modes of delivery for providers to submit prior authorization requests such as telephone, fax, or electronically through a portal on the Contractor's website.

The Contractor shall ensure providers who request authorization for a service are notified that they have the option to request a peer to peer discussion with the Contractor Medical Director when additional information is requested by the Contractor or when the prior authorization request is denied. The Contractor shall coordinate the discussion with the requesting provider when appropriate.

The Contractor shall develop and implement policies and procedures, coverage criteria and processes for approval of covered services, which include required time frames for authorization determination.

1. Policies and procedures for approval of specified services shall:
   a. Identify and communicate to providers, TRBHAs, and members those services that require authorization and the relevant clinical criteria required for authorization decisions. Services not requiring authorization must also be identified. Methods of communication with members include newsletters, Contractor website, and/or member handbook. Methods of communication with providers and TRBHAs include newsletters, Contractor website, and/or provider manual. Changes in the coverage criteria must be communicated to members, TRBHAs and providers 30 days prior to implementation of the change,
   b. Delineate the process and criteria for initial authorization of services and/or requests for continuation of services. Criteria must be made available to providers and TRBHAs through the provider manual and Contractor website. Criteria must be available to members upon request,
   c. Authorize services in a sufficient amount, duration or scope to achieve the purpose for which the services are furnished,
   d. Ensure consistent application of review criteria,
   e. Specify timeframes for responding to requests for initial and continuous determinations for standard and expedited authorization requests as defined in ACOM Policy 414 and 42 CFR 438.210.
   f. Provide decisions and notice as expeditiously as the member's health condition requires and no later than 72-hours after receipt of an expedited service request pursuant to 42 CFR 438.210(d)(2)(i),
   g. Provide for consultation with the requesting provider and TRBHA when appropriate, and
   h. Review all PA requirements for services, items or medications annually. The review must be reported through the MM Committee and shall include the rationale for changes made to prior authorization requirements and must be documented in the MM Committee meeting minutes.

2. Contractors shall develop and implement policies for processing and making determinations for prior authorization requests for medications. The Contractor shall ensure the following:

a. A decision to a submitted prior authorization request for a medication is provided by telephone, fax, electronically or other telecommunication device within 24 hours of receipt of the submitted request for prior authorization,
b. A request for additional information is sent to the prescriber by telephone, fax, electronically or other telecommunication device within 24 hours of the submitted request when the prior authorization request for a medication lacks sufficient information to render a decision. A final decision shall be rendered within seven business days from the initial date of the request,
c. At least a 4-day supply of a covered outpatient prescription drug is provided to the member in an emergent situation. [42 CFR 438.3(s)(6)].

3. The Contractor criteria for decisions on coverage and medical necessity for both physical and behavioral services must be clearly documented, based on reasonable medical evidence or a consensus of relevant health care professionals:
   a. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a medically necessary service solely because of the setting, diagnosis, type of illness or condition of the member,
   b. The Contractor may place appropriate limits on services based on a reasonable expectation that the amount of service to be authorized will achieve the expected outcome, and
   c. The Contractor shall have criteria in place to make decisions on coverage when the Contractor receives a request for service involving Medicare or other third party payers. The fact that the Contractor is the secondary payer does not negate the Contractor's obligation to render a determination regarding coverage within the timeframes established by "1e" in this section. Refer to ACOM Policy 201 for additional information regarding Contractor payment and cost sharing responsibilities.

E. INTER-RATER RELIABILITY

The Contractor must have in place a process to ensure consistent application of review criteria in making medical necessity decisions which include prior authorization, concurrent review, and retrospective review. Inter-rater Reliability testing of all staff involved in these processes must be done at least annually. A corrective action plan must be included for staff who do not meet the minimum compliance goal of 90%.

F. RETROSPECTIVE REVIEW

The Contractor must conduct a retrospective review which is guided by the following.

1. Policies and procedures:
   a. Include the identification of health care professionals with appropriate clinical expertise who are responsible for conducting retrospective reviews,
   b. Describe services requiring retrospective review, and
   c. Specify time frame(s) for completion of the review.

2. Criteria for decisions on medical necessity must be clearly documented and based on reasonable medical evidence or a consensus of relevant health care professionals.

3. A process for consistent application of review criteria.

4. Guidelines for Provider-Preventable Conditions.

   Title 42 CFR Section 447.26 prohibits payment for services related to Provider-Preventable Conditions. Provider-Preventable Condition means a condition that meets the definition of a HCAC or an OPPC .

   A member's health status may be compromised by hospital conditions and/or medical personnel in ways that are sometimes diagnosed as a "complication". If it is determined that the complication resulted from an HCAC or OPPC, any additional hospital days or other additional charges resulting from the HCAC or OPPC will not be reimbursed.

   If it is determined that the HCAC or OPPC was a result of a mistake or an error by a hospital or medical professional, the Contractor must conduct a Quality of Care (QOC) investigation and report the occurrence and results of the investigation to the AHCCCS Clinical Quality Management Unit.

G. CLINICAL PRACTICE GUIDELINES

1. The Contractor shall develop or adopt and disseminate practice guidelines for physical and behavioral health services that:
   a. Are based on valid and reliable clinical evidence or a consensus of health care professionals in that field [42 CFR 438.236(b)(1)],
   b. Have considered the needs of the Contractor's members [42 CFR 438.236(b)(2)],
   c. Are adopted in consultation with contracting health care professionals and National Practice Standards [42 CFR 438.236(b)(3)], or
   d. Are developed in consultation with health care professionals and include a thorough review of peer-reviewed articles in medical journals published in the United States when national practice guidelines are not available. Published peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results and with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale,
   e. Are disseminated by the Contractor to all affected providers and TRBHAs, upon the request, to members and potential members, and
   f. Provide a basis for consistent decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply [42 CFR 438.236(d)].

2. The Contractor shall annually evaluate the Practice Guidelines through a MM multi-disciplinary committee to determine if the guidelines remain applicable, represent the best practice standards, and reflect current medical standards [42 CFR 438.236(b)(4)].

3. The Contractor shall document the review and adoption of the practice guidelines as well as the evaluation of efficacy of the guidelines in the MM Committee meeting minutes.

H. NEW MEDICAL TECHNOLOGIES AND NEW USES OF EXISTING TECHNOLOGIES

1. The Contractor shall develop and implement written policies and procedures for evaluating new technologies and new uses of existing technology. The policies and procedures must include the process and timeframe for making a clinical determination when a time sensitive request is made. A decision in response to an urgent request must be made as expeditiously as the member's condition warrants and no later than 72 hours from receipt of the request.

2. The Contractor shall include coverage decisions by Medicare intermediaries and carriers, national Medicare coverage decisions, and Federal and State Medicaid coverage decisions.

3. The Contractor shall evaluate peer-reviewed medical literature published in the United States. Peer-reviewed medical literature must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

4. The Contractor shall establish:
   a. Coverage rules, practice guidelines, payment policies, policies and procedures, utilization management, and oversight that allows for the individual member's medical needs to be met,
   b. A process for change in coverage rules and practice guidelines based on the evaluation of trending requests. Additional review and assessment is required if multiple requests for the same technology or application of an existing technology are received, and
   c. A process for documenting the coverage determinations and rationale in the MM Committee meeting minutes.

I. CONTRACTOR CARE MANAGEMENT

The Contractor shall establish a process to ensure coordination of member physical and behavioral health care needs across the continuum based on early identification of health risk factors or special care needs, as defined by the Contractor. Coordination must ensure the provision of appropriate services in acute, home, chronic and alternative care settings that meet the member's needs in the most cost-effective manner available.

Contractor care managers are expected to have direct contact with members for the purpose of providing information and coordinating care, but are not performing the day-to-day duties of the ALTCS Contractor case manager, the provider case manager, or TRBHA and Tribal ALTCS case manager. Contractor care management shall occur at

the MCO level or TRBHA level and cannot be delegated down to the provider level. Contractor care management is an administrative function.

Care managers identify and manage clinical interventions or alternative treatments for identified members to reduce risk, cost, and help achieve better health care outcomes. Contractor care managers work closely with ALTCS contractor case managers and provider case managers to ensure the most appropriate plan and services for members.

NOTE: Arizona Long Term Care System (ALTCS) Contractor and Tribal ALTCS must also refer to the additional ALTCS Case Management Standards as specified in AMPM Policy 1620.

The Contractor shall develop a plan outlining short- and long-term strategies for improving care coordination using the physical and behavioral health care data available for members with behavioral health needs. In addition, the Contractor shall develop an outcome measurement plan to track the progress of the strategies. The plan outlining the strategies for improving care coordination and the outcome measurement must be reported in the annual MM Plan, Evaluation and Work Plan submitted to AHCCCS as specified in contract.

1. The Contractor shall establish policies and procedures that reflect integration of services to ensure continuity of care by:
   a. Ensuring that, in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements including, but not limited to, [45 CFR Parts 160 and 164, Subparts A and E], Arizona statutes and regulations, and to the extent that they are applicable [42 CFR 438.208 (b)(2) and (b)(4) and 438.224],
   b. Allowing each member to select a Primary Care Provider (PCP), TRBHA, and a behavioral health provider, if appropriate, who is formally designated as having primary responsibility for coordinating the member's overall health care,
   c. Ensuring each member has an ongoing source of care appropriate to his or her needs 438.208(b)(1),
   d. Ensuring each member receiving care coordination has a person or entity that is formally designated as primarily responsible for coordinating services for the member, such as the Contractor care manager, ALTCS Contractor or provider case manager. The member must be provided information on how to contact their designated person or entity [438.208(b)(1)],
   e. Specifying under what circumstance services are coordinated by the Contractor, including the methods for coordination and specific documentation of these processes,
   f. Coordinating the services for members between settings of care including appropriate discharge planning for short-term and long-term hospital and institutional stays [42 CFR 438.208(b)(2)(i)],
   g. Coordinating covered services with the services the member receives from another Contractor and/or FFS [42 CFR 438.208(b)(2)(ii) and (iii)],
   h. Coordinating covered services with community and social support services that are generally available through contracting or non-contracting providers, in the Contractor service area [42 CFR 438.208(b)(2)(iv),

i. Ensuring members receive End of Life Care and Advance Care Planning as specified in AMPM Policy 310-HH,
j. Establishing timely and confidential communication of clinical information among providers, as specified in AMPM Policy 940. This includes the coordination of member care between the PCP, Contractor, and TRBHA. At a minimum, the PCP must communicate all known primary diagnoses, comorbidities, and changes in condition to the Contractor or TRBHA when the PCP becomes aware of the Contractor or TRBHA involvement in care,
k. Ensuring that Contractor and TRBHA are providing pertinent diagnoses and changes in condition to the PCP in a timely manner. Contractor must facilitate this communication exchange as needed and establish monitoring activities such as record review to ensure that the exchange occurs as follows:
    i. "Urgent" – Requests for intervention, information, or response within 24 hours, and
    ii. "Routine" – Requests for intervention, information or response within 10 days.
l. Educating and communicating with PCPs who treat any member with diagnoses of depression, anxiety or Attention Deficit Hyperactivity Disorder (ADHD) that care requirements include but are not limited to:
    i. Expectations described in "d" of this section, and
    ii. Monitoring the member's condition to ensure timely return to the PCP's care for ongoing treatment, when appropriate, following stabilization by a Contractor.
m. Ensuring that Contractor care managers provide consultation to a member's inpatient and outpatient treatment team and/or directly engage the member as part of the contractor care management program,
n. Ensuring policies reflect care coordination for members presenting for care outside of the Contractor's provider network,
o. Monitoring controlled and non-controlled medication. The Contractor shall restrict members to an exclusive pharmacy or prescriber as specified in AMPM Policy 310-FF,
p. Meeting regularly with the Contractor and the AHCCCS administration for Fee for Service members to coordinate care for members with high behavioral and physical health needs and/or high costs. High level Contractor meetings shall occur at least every other month or more frequently if needed to discuss barriers and outcomes. Care coordination meetings and staffing meetings shall occur at least monthly, or more as often as necessary, to affect change. The Contractor shall implement the following:
    i. Identification of High Need/High Cost members as required in contract,
    ii. Plan interventions for addressing appropriate and timely care for these identified members, and
    iii. Report outcome summaries to AHCCCS as specified in Contract.

2. The Contractor shall develop policies and implement procedures for members with special health care needs, as specified in AMPM Policy 540 and Contract, including:
    a. Identifying members with special health care needs,

b. Ensuring an assessment by an appropriate health care professional for ongoing needs of each member identified as having special health care needs or conditions,
c. Ensuring adequate care coordination among providers or TRBHAs, and
d. Ensuring a mechanism to allow direct access to a specialist as appropriate for the member's condition and identified special health care needs (e.g., a standing referral or an approved number of visits).

3. The Contractor shall implement measures to ensure that members receiving contractor care management:
   a. Are informed of particular health care conditions that require follow-up,
   b. Receive, as appropriate, training in self-care and other measures they may take to promote their own health, and
   c. Are informed of their responsibility to comply with prescribed treatments or regimens.

4. The Contractor shall have in place a contractor care/ management process whose primary purpose is the application of clinical knowledge to coordinate care needs for members who are medically, physically and/or behaviorally complex and require intensive medical and psychosocial support.

   The Contractor shall develop member selection criteria for contractor care management model to determine the availability of services, and work with the member's provider(s) or TRBHA. The contractor care manager works with the ALTCS contractor case manager, provider case manager, and TRBHA and Tribal ALTCS case manager, PCP and/or specialist to coordinate and address member needs in a timely manner. The contractor care manager must continuously document interventions and changes in the plan of care.

5. The contractor care management individualized care plan will focus on achieving member wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The contractor care manager must also assist the member in identifying appropriate providers, TRBHAs, and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value for both the member and the Contractor.

   Contractor must provide oversight and monitoring of contractor care management that is subcontracted or inclusive in a providers' contractual agreement. The contractor care management role must comply with all AHCCCS requirements.

6. In addition to care coordination as specified in their contract with AHCCCS, Contractor must proactively provide care coordination for members who have multiple complaints regarding services or the AHCCCS Program. This includes members who do not meet the Contractor criteria for contractor care management, as well as, members who contact governmental entities for assistance, including AHCCCS.

Contractor shall identify and coordinate care for members with Opioid Use Disorders and ensure access to appropriate services such as MAT and Peer Support Services.

9. Contractor shall develop and implement policies and procedures to provide high touch contractor care management or other behavioral health and related services to members on Conditional Release from the Arizona State Hospital (AzSH) consistent with the Conditional Release Plan (CRP) issued by the Psychiatric Security Review Board PSRB, including but not limited to assignment to a contractor care manager. Contractor may not delegate the contractor care management functions to a subcontracted provider.

   The contractor care manager is responsible for at minimum the following:
   a. Coordination with AzSH for discharge planning,
   b. Participating in the development and implementation of Conditional Release Plans,
   c. Participation in the modification of an existing or the development of a new Individual Service Plan (ISP) that complies with the Conditional Release Plan (CRP),
   d. Member outreach and engagement to assist the PSRB in evaluating compliance with the approved CRP,
   e. Attendance in outpatient staffing at least once per month, and
   f. Care coordination of care with the member's treatment team, TRBHA, and providers of both physical and behavioral health services to implement the ISP and the CRP,
   g. Routine delivery of comprehensive status reporting to the PSRB,
   h. Attendance in a monthly conference call with AHCCCS Medical Management (MM),
   i. In the event a member violates any term of his or her CRP the Contractor shall immediately notify the PSRB and provide a copy to AHCCCS and AzSH, and
   j. The Contractor further agrees and understands it shall follow all obligations, including those stated above, applicable to it as set forth in A.R.S. §13-3994.

   Any violation of the Conditional Release, psychiatric decompensation or use of alcohol, illegal substances or prescription medications not prescribed to the member shall be reported to the PSRB and the AzSH immediately.

   Contractor shall submit a monthly comprehensive status report for members on Conditional Release to the PSRB and AHCCCS MM, as specified in Contract utilizing AMPM Attachment 1020-1. Contractor shall provide additional documentation at the request of AHCCCS MM. In the event that a member's mental status renders him/her incapable or unwilling to manage his/her medical condition and the member has a skilled medical need, the Contractor must arrange ongoing medically necessary nursing services in a timely manner.

10. Contractor must identify and track members who utilize Emergency Department (ED) services inappropriately four or more times within a six month period. Interventions must be implemented to educate the member on the appropriate use of the ED and divert members to the right care in the appropriate place of service.

Contractor care management interventions to educate members should include, but are not limited to:

a. Outreach phone calls/visits,
b. Educational Letters,
c. Behavioral Health referrals,
d. High Need/High Cost Program referrals,
e. Disease Management referrals, and
f. Exclusive Pharmacy referrals.

Contractor shall submit the bi-annual ED Diversion Report to AHCCCS as specified in Contract. The report must identify the number of times the Contractor intervenes with members.

11. The RBHA and CRS Contractor shall monitor the length of time adults and children wait to be discharged from the Emergency Department (ED) while awaiting behavioral health placement or wrap around services. Immediately upon notification that a member who needs behavioral health placement or wrap around services is in the ED the Contractor shall coordinate care with the ED and the member's treatment team to discharge the member to the most appropriate placement or wrap around services. Additionally, the Contractor shall submit the Adult and Child ED Wait Times Report utilizing Attachment 1020-2 as required in Section F, Attachment F3, Contractor Chart of Deliverables.

12. The Contractor (excluding CMDP) shall develop and implement policies and processes to conduct reach-in care coordination for members who have been incarcerated. The Contractor shall utilize 834 file data to develop a process for identifying members who meet the established parameters for reach-in care coordination (e.g., definition of chronic and/or complex care needs, including assessment and identification of MAT eligible members prior to release).

    Criminal Justice System reach-in care coordination facilitates the transition of members transitioning out of jails and prisons into communities. AHCCCS is engaged in a data exchange process that allows AHCCCS to suspend eligibility upon incarceration, rather than terminate coverage. Upon the member's release, the member's AHCCCS eligibility is un-suspended allowing for immediate care coordination activities. To support this initiative the Contractor is required to participate in criminal justice system "reach-in" care coordination efforts.

    The Contractor shall conduct reach-in care coordination for members who have been incarcerated in the adult correctional system for 30 days or longer, and have an anticipated release date. Reach-in care coordination activities shall begin upon knowledge of a member's anticipated release date. The Contractor shall collaborate with criminal justice partners (e.g. Jails, Sherriff's Office, Correctional Health Services, Arizona Department of Corrections, including Community Supervision, Probation, Courts), to identify justice-involved members in the adult criminal justice system with physical and/or behavioral health chronic and/or complex care needs prior to member's release. When behavioral health needs are identified, the Contractor shall also

collaborate with the member's behavioral health Contractor (if the member's care is not integrated).

The Contractor shall report the Reach-In Plan to AHCCCS, as described below, in the annual Medical Management Plan and report outcome summaries in the Medical Management Evaluation, as specified in Contract. The Contractor shall monitor progress throughout the year and submit quarterly reporting to AHCCCS, as specified in Contract, of the number of members involved in reach-in activities. In addition, AHCCCS may run performance metrics such as emergency room utilization, inpatient utilization, reduction in recidivism and other access to care measures for the population to monitor care coordination activities and effectiveness.

Reach-in Plan Administrative Requirements:

a. Designation of a Justice System Liaison who will be responsible for the reach-in initiative and who:
    i. Resides in Arizona,
    ii. Is the single point of contact to communicate with the court and justice systems and AHCCCS Acute Care Contractor, including interaction with Mental Health Courts, Drug Courts, and other jail diversion programs, including serving as the single point of contact for law enforcement engaging in opioid-related diversion and incarceration alternative projects, and
    iii. Is the interagency liaison with the Arizona Department of Corrections (ADOC), County Jails, Sherriff's Office, Correctional Health Services, Arizona Office of the Courts (AOC) and Probation Departments.
b. Identification of the name(s) and contact information for all criminal justice system partner(s)
c. Identification of the name(s) and contact information for RBHA partner(s) for purposes of coordinating care for both physical and behavioral health needs
d. Description of the process for coordination with jails, when necessary for identification of those members in probation status
e. Designation of parameters for identification of members requiring reach-in care coordination (e.g. definition of chronic and/or complex care needs) through agreement with reach-in partners
f. Description of the process and timeframes for communicating with reach-in partners
g. Description of the process and timeframes for initiating communication with reach-in members
h. Description of methodology for assessment of anticipated cost savings to include analysis of medical expense for these identified members prior to incarceration and subsequent to reach in activities and release.

Reach-in Plan Care Coordination Requirements:

a. Develop process for identification of members meeting the established parameters for reach-in care coordination with chronic and/or complex care needs, including assessment and identification of MAT eligible members prior to release). The Contractor must utilize the 834 file data provided to the Contractor by AHCCCS to assist with identification of members. The Contractor may also use additional data if available for this purpose.

b. Strategies for providing member education regarding care, services, resources, appointment information and health plan care management contact information
c. Requirements for scheduling of initial appointments with appropriate provider(s) or TRBHA based on member needs, appointment to occur within seven days of member release
d. Strategies regarding ongoing follow up with the member after release from incarceration to assist with accessing and scheduling necessary services as identified in the member's care plan, including access to all three FDA approved MAT options covered under the AHCCCS Behavioral Health Drug List and assignment to peer support services to help navigate and retain the member in MAT when appropriate.
e. Should re-incarceration occur, strategies to reengage member and maintain care coordination
f. Strategies to improve appropriate utilization of services
g. Strategies to reduce recidivism within the member population
h. Strategies to address social determinants of health

The Contractor must notify AHCCCS upon becoming aware that a member may be an inmate of a public institution when the member's enrollment has not been suspended, and will receive a file from AHCCCS as specified in Section D, Paragraph 54, Capitation Adjustment.

13. The Maricopa County RBHA Contractor shall develop policies and processes to collaborate with the Arizona Department of Corrections (ADC) to provide contractor care management to members enrolled in the Governor's Vivitrol Treatment Program, as required by Executive Order 2017-01. The Vivitrol treatment program will only be initiated for individuals being released from prison to Maricopa County. Individuals who have been determined eligible for Vivitrol treatment will receive a monthly injection of Vivitrol for up to 12 months to treat opioid dependence. Vivitrol will not be prescribed to pregnant or breast feeding women.

    The Contractor shall designate a care manager to provide contractor care management to members enrolled in the Vivitrol treatment program.

    Upon notification from the ADC Reentry Planner that a member is enrolled in the program and will be released in 30 days, the designated contractor care manager will collaborate with the Reentry Planner and the ADC provider to determine the member's appropriateness for participation in the Vivitrol treatment program. To qualify for entry into the program individuals must be eligible for Medicaid, commit to participate in the program both pre and post release and sign necessary releases of information and consent to participate, as well as:
    a. Have a history of opioid dependence,
    b. Be identified as a potential candidate for the program at least 30 days prior to release,
    c. Commit to participate in substance use counseling pre and post release and Medication Assisted Treatment (MAT),
    d. Be screened using evidenced based American Society of Addiction Medicine (ASAM, Third Edition) criteria,

e. Pass urinalysis tests,
f. Pass the Naloxone challenge test (to be done three to seven days prior to first injection),
g. Be screened for physical and/or behavioral health comorbidities that may make the member ineligible for Vivitrol,
h. Be free from any medical conditions which contraindicate participation
i. Be administered the Vivitrol two to three days prior to release,
j. Be released to the community under either county or ADC community supervision, and
k. Be released to Maricopa County.

The Contractor care manager shall also:
a. Confirm that the member received pre-release counseling and is scheduled for post release counseling and MAT related to Vivitrol treatment from the ADC provider,
b. Coordinate the referral with the MAT specialist who has agreed to prescribe and administer the post-release Vivitrol,
c. Provide accessibility to Naloxone and substance use treatment. Naloxone will be provided to whoever supports the member. If the member has no formal or informal support, the Naloxone will be provided directly to the member with instructions for the purpose and use by the provider within 72 hours following release from incarceration
d. Act as a liaison between the ADC provider responsible for administering the first injection of Vivitrol and the MAT specialist,
e. Schedule a post release appointment with the MAT specialist within seven days of administration of last injection, and
f. Schedule counseling and other needed behavioral health services as applicable
g. Support the MAT specialist in identifying an alternate treatment if Vivitrol is not the appropriate course of treatment.

The Contractor shall submit a semi-annual Vivitrol Treatment Program Report to AHCCCS as specified in Maricopa County Integrated RBHA Contract, Exhibit-9. The report must identify:
a. The name of the member participating in the program,
b. The member's ADC # and AHCCCS ID,
c. The date of the member's first injection,
d. The date the member was released from prison,
e. The name of the post release prescriber,
f. First appointment and then track monthly appointment (Received second shot and engaged in treatment in the first month),
g. Length of stay in treatment (e.g. end date),
h. Vivitrol end date and reason,
i. If member decides to change medication,
j. Compliance with treatment (e.g., regular drug screens),
k. Report on data monthly,
l. Member satisfaction ,
m. Overdose/death and reason,
n. Successfully completed their term of supervision,
o. Recidivism ,

p. Positive drug screen,
q. Emergency department, and
r. Hospital admission.

J. CONTRACTOR DISEASE/CHRONIC CARE MANAGEMENT

Contractor must implement a Disease/Chronic Contractor Care Management Program that focuses on members with high risk and/or chronic conditions that have the potential to benefit from a concerted intervention plan. The goal of the Disease/Chronic Contractor Care Management Program is to increase member self-management and improve practice patterns of providers, thereby improving healthcare outcomes for members.

1. The Contractor MM Committee must focus on selected disease conditions based on utilization of services, at risk population groups, and high volume/high cost conditions to develop the Disease Management Program.

2. The Disease Management Program must include, but is not limited to:
   a. Members at risk or already experiencing poor health outcomes due to their disease burden,
   b. Health education that addresses the following :
      i. Appropriate use of health care services,
      ii. Health risk-reduction and healthy lifestyle choices including tobacco cessation,
      iii. Screening for tobacco use with the Ask, Advise, and Refer model and refer to the Arizona Smokers Helpline utilizing the proactive referral process,
      iv. Self-care and management of health conditions, including wellness coaching,
      v. Self-help programs or other community resources that are designed to improve health and wellness,
      vi. EPSDT services for members including education and health promotion for dental/oral health services, and
      vii. Maternity care programs and services for pregnant women including family planning
   c. Interventions with specific programs that are founded on evidence based guidelines,
   d. Methodologies to evaluate the effectiveness of programs including education specifically related to the identified members' ability to self-manage their disease and measurable outcomes,
   e. Methods for supporting both the member and the provider in establishing and maintaining relationships that foster consistent and timely interventions and an understanding of and adherence to the plan of care,
   f. Components for providers include, but are not limited to:
      i. Education regarding the specific evidenced based guidelines and desired outcomes that drive the program,
      ii. Involvement in the implementation of the program,
      iii. Methodology for monitoring provider compliance with the guidelines, and
      iv. Implementation of actions designed to bring the providers into compliance with the practice guidelines.

K. DRUG UTILIZATION REVIEW

Drug Utilization Review (DUR) is a systematic, ongoing review of the prescribing, dispensing and use of medications. The purpose of DUR is to assure efficacious, clinically appropriate, safe, and cost-effective drug therapy to improve member health status and quality of care.

Contractor must develop and implement a system, including policies and procedures, coverage criteria and processes for their DUR programs.

1. Criteria for decisions on coverage and medical necessity must be clearly documented and based on the scientific evidence and standards of practice that include, but are not limited to, peer-reviewed medical literature, outcomes research data, official compendia, or published practice guidelines developed by an evidence-based process.

2. Contractor must manage a DUR program that includes, but is not limited to:
   a. Prospective review process for:
      i. All drugs prior to dispensing. This review process may be accomplished at the pharmacy using a computerized DUR system. The DUR system, at minimum, must be able to identify potential adverse drug interactions, drug-pregnancy conflicts, therapeutic duplication and drug-age conflicts, and
      ii. All non-formulary drug requests.
   b. Concurrent drug therapy of selected members to assure positive health outcomes,
   c. Retrospective drug utilization review process to detect patterns in prescribing, dispensing, or administration of medication and to prevent inappropriate use or abuse. The review process serves as a means of identifying and developing prospective standards and targeted interventions,
   d. Pattern analyses that evaluates clinical appropriateness, over and underutilization, therapeutic duplication, drug-disease contraindication, drug-drug interaction, incorrect duration of drug treatment, clinical abuse or misuse, use of generic products and mail order medications,
   e. Tracking and trending must be implemented specific to CMDP members being prescribed psychotropic medications:
      i. Results should be documented and reported to AHCCCS on a quarterly basis, via the EPSDT/Adult Quarterly Monitoring Report (Appendix A) and as specified in Contract,
      ii. If providers are found to be prescribing four or more concurrent psychotropic medications to CMDP members, the Contractor must conduct a comprehensive chart review for each CMDP member. The chart reviews must be completed by a subject matter expert (board eligible or certified child and adolescent psychiatrist),
   f. Provision for education of prescribers and Contractor professionals on drug therapy problems based on utilization patterns with the aim of improving safety, prescribing practices and therapeutic outcomes. The program must include a summary of the educational interventions used and an assessment of the effect of these educational interventions on the quality of care.